Newsletter No:8...DECEMBER 1997

SMMGP

Substance Misuse Management in General Practice Newsletter

Motivational Interviewing

Brian Whitehead

Counsellor in General Practice

Motivational Interviewing is cited as a popular method of intervention within the field of drugs and alcohol. It is considered by many to be an effective tool for working with people with "compulsive" or "addictive" behaviour. In a recent survey of alcohol workers the model was cited as the most influential in assisting theoretical understanding of change, and has been regarded by some as the most important and innovative therapeutic intervention of the 1980's.

At the second National Conference on "Managing Drug Users in General Practice", Dr Tom Waller spoke of the need "to consider the non-prescribing side of the treatment package", and to give attention to the counselling interventions that can be used to assist people to change. Dr Waller reported that there was much to be learnt form the alcohol field where methods of interventions have been more consistently applied for longer periods, and been more systematically tested and evaluated.

Motivational Interviewing is one such approach that has gained enormous popularity in the last decade, and one that is being applied in many different clinical setting where the agenda is one of change.

It is useful with people who express ambivalence or "resistance" to change and who are unresolved about change. When clients/patients attend for treatment it is often presumed that they have resolved their ambivalence about change, are prepared to give up old established behaviour, have made a decision and are keen to get on with a change process. What is often recognised however is that many drug users are clearly unresolved and in conflict about many behaviours in their lives.

Motivational Interviewing is a client centred approach that strategically directs clients to examine, explore, and resolve the ambivalence they have about their behaviour. It works with the clients own agenda to explore change, exploring the resistance people have to change, and by working creatively with an individuals attachment and ambivalence to certain behaviours. Motivational interviewing works on the assumption that people have implicit attachments to the behaviours they engage in, in other words they are functional to the person. In order to assist people to change it is important to be able to work strategically with the client to support them override their attachment to the behaviour, resolve their ambivalence before moving onto change.

In other words as a practitioner we work with the natural resistance that is characterised in people with addictive behaviours, using techniques and strategies to direct towards change based on the "Stages of Change Model", developed by Prochaska and DiClemente. This simple six staged model describes a cycle through which people progress as they begin to consider and recognise that they have a problem, weigh up the pros and cons of change and decide to change, (or not!).

Pre-contemplation stage of change

relapsing to previous behaviour **Contemplation**

maintaining changed behaviour **Decision to change**

Action - changing

Precontemplation: A stage where people do not identify that they have a problem, and are not thinking about change. Others, or external agents may perceive that there is a problem but it is not internalised by the client.

Contemplation: A stage where someone begins to weigh up the pros and cons of their behaviour, thinking about whether there may be a problem or not, and whether change is either necessary or desirable.

Decision: A stage where someone decides to do something to change their behaviour.

A point at which there is a conscious decision to do something.

Action: The process of actively doing something. The person chooses a strategy for change and pursues it, taking steps to put their decision into action.

Maintenance: A stage of actively working on and maintaining change strategies. This is a stage of conscious effort and attention to sustaining change strategies.

Lapse or Relapse. A stage where the client either slips (lapses) back from a strategy to change, or return to previous levels and patterns of behaviour(relapse).

- It is important to be able to assess in which stage a clients is in relation to each behaviour. Strategies for precontemplation are different from strategies for a client in action.
- Practitioners should initially work in areas of least resistance i.e. where the client is furthest in the cycle.

The goal of MI is to elicit self motivational statements from the client about change, and direct these statements towards change. As practitioners we actively seek out statements that reflect 5 key motivational areas;

1. ***Self Esteem***: Statements from the client that they are OK. People have to believe they are OK to be able to change. Raising self esteem is a cornerstone of MI.
2. ***Concern***: Statements from the clients that express concern about their behaviours.
3. ***Competence***: Statements from the client reflecting an ability to do things.
4. ***Knowledge of Problem***: Statements from clients recognising problem behaviour.
   Knowledge of Strategies: Statements reflecting strategies for change.
5. ***Desire to Change***: Statements that reflect a desire for things to be different.

We actively use these *self motivational statements* to create a state of *internalised conflict* in the client, to allow them to experience the conflict between present and desired behaviour, and to assist them to make informed decisions about change. However it is important that clients are the ones who articulate the need to change and are able to attribute change to themselves. *Supporting self esteem* and *self efficacy* becoming central strategies in this process. As practitioners we *"roll with resistance"*, finding positives in no change, and encouraging the client to be the one who tells us that they have a problem and want to change. In other words as practitioners we leave *clients with the responsibility* for their behaviour, to be the ones who talk of change, but are active in reflecting any *conflict* we hear about their behaviour, and actively "*developing discrepancy"* wherever it is heard.

In MI we *elicit* self motivational statements in order to encourage the client to identify whether there is a problem or not. Once a client recognises that there is a problem, with the strategic gathering of *information* about that behaviour and the gathering of objective data about that behaviour clients can decide whether to change or not. Once a decision to change has been reached with the support of the professional practitioner appropriate strategies for change can be *negotiated.*

Further Reading: Miller, W. Rollnick. S, (Eds). (1991) Motivational Interviewing. Guildford Press.

IMPORTANT NOTICE

3rd National Conference, 'Managing Drug Users in General Practice'. April 24th 1998 - in Edinburgh

To continue the debate.....Examining and exploring the role of general practice and primary care in the management of drug users.

Key themes: "Shared- care" ; "Beyond methadone", Effective Research for primary care, What works? Political changes in Primary care and how they affect care of drug users.

"Talking therapies", Alternatives to methadone, Stimulants, Cocaine, Benzodiazepines, Recreational drugs. Public Health Vs Personal Right.

Invitations for Speakers, Workshop leaders and Poster Presentations. Would you like to facilitate a workshop, or present a key note speech on any of the above ? Or do you know the perfect person to give an overview of the changes in Primary Care in England, Wales and Scotland and how these help or hinder the care of drug users?

Don't be bashful about coming forward!! Please contact Dr Chris Ford at the SMP (Substance Misuse Management Project) on 0181 966 1109 **before 5.1.98 if possible**.

Conference Report: 'DRUG-USERS ~ SCAPEGOATS or ACTIVISTS?'
organised by drug users for drug users on Monday October 27th 1997

It is clear that drug users have and should have a lot to say about drug users rights, access to treatment, the choices they are given and how they are treated by 'society'.It is apparent that drug users are capable of contributing to rational decision-making about their treatment (1).

As there has been expansive of local drug users groups it has become clear that a national drug users rights forum was needed so new groups could learn from the successes and failures of others and a need to unite to gain a larger voice.

We heard that Sam Friedman was coming to London and we wondered if he could be the catalyst to bring drug user groups together. He works in New York and has been a leader in the harm-reduction movement and written papers on drug user activism, self-organisation of drug users and the significant role of drug users in the fight against HIV infection and other blood-borne viruses.

The idea of the conference 'Drug Users - Scapegoats or Activists' was hence launched and organised by two users unions -**RESPECT** (Drug Users Union in East London) and **BSURF** (Brent Substance Users Rights Forum) and their supporters. People came from far and wide including Scotland, Ireland, Manchester, Leeds, Nottingham and London! Most of the 140 were current or ex-users and they came together in a completely packed to capacity hall.

The atmosphere was electric and the conference was begun by a representative from BSURF outlining her existence as a heroin user, stealing and shoplifting to pay for her drugs. She talking about her personal experience of scapegoating and the prejudice she had experienced from society and health professionals. She spoke of all the hoops that users have to jump through (particularly in the specialist clinics) in order to obtain help, the lack of choice she had been given in treatment and the attitude of many of the drug workers who seemed to want to make the whole experience degrading for users. She said there was always the fear of not getting the methadone for contravening on one rule or another - as if users didn't have enough fear in their lives already!

Finally she encouraged users to become active, to turn all the energy of keeping a habit going, into something that would improve the situation for users - **'The Titanic built by professionals; the Ark built by amateurs'.**

Sam Friedman of the National Development and research Institutes Inc., USA then spoke. He began with a resume of what he called the political economy of scapegoating. The war of drugs was failing so what was the logic of keeping it going? In those interests was this being fought?
He noted there were problems for the West, primarily: declining profits, international competition and globalisation of product. All this means that there is less profit which leads to less investment which is a threat to national economies, jobs etc., reductions in public

spending to compete, reduction in salaries and changes in belief systems. The buzz-words include efficiency, productivity and deregulation. There is a new Puritanism abroad and a disruption of communities in which people lose hope.

So if the people are fighting back the best weapon is divide and rule and also to scapegoat. The object is to play on peoples fears and frustrations. Drug users are especially easy to scapegoat, crime and violence which can happen in the drug world make it even easier. Local users are blamed for everything that goes on in the community and the blame is focused on individuals rather than on the economic and social structure that has created the drug situation. In fact, the more harm is caused by drugs, the easier it is for the authorities to maintain power.

Sam showed clearly that drug users responded to the HIV epidemic in New York by reducing sharing long before the medical profession looked at the problem. As early as 1978 users began to see a problem. When medicine discovered AIDS in 1981 users began to work out it had something to do with sharing needles and sharing began to reduce. Needle exchanges were finally set up in New York in 1992-3. **(N.B. this was very different to what happened in the UK where the potential threat was seen and needle exchanges set up early helped to avert a HIV epidemic in drug users(2))**

He then went on explain what user organisations and groups can do. They can help with harm reduction, advice on blood borne viruses, act as a pressure group against the demonisation of drug users and act as a consumer group in relation to drug dealers, such as warning about bad drugs. Users need to relate to the popular constituency, engage the local community, the social networks and find allies. The imperative is to maximum strength of solidarity, but minimise risky behaviours. He discussed the need to build up primary groups and recruit leaders from these.

The discussion was then opened to the floor and as Sam said in his closing remarks what he had seen and heard on that night was much better than in the professional groups and even some established user groups.

The discussion covered a number of points and the crucial question that needed answering was - where do we go from here? The need to focus, rather than dissipating the effort by trying to take on too many issues at once, be consistent, keep the message simple, need to make sure that women's issues are properly addressed and use already available vehicles such as the Mainliners Newsletter and the Internet to communicate
(the international drug users forum already uses the internet successfully). How can active users in paid jobs be encouraged to come out without a threat to their positions? The need to find allies, for example in the mental health movement and push drug
agencies on the issue of drug users rights - those drug workers who don't advocate for drug users should be challenged.

Many things need to be addressed: - choice in treatment - challenge the hegemony of methadone, change the emotive language of drugs, change the drug laws and eventually move

towards decriminalisation of all drugs and legalisation. Drugs should be a public health not a legal problem. In respect of harm reduction for example, it is
difficult to do anything with the law in place. Civil disobedience campaign / direct action could be used. Boycott dictatorial run specialist services to make a point about the balance of power between user and worker.

The meeting was closed with the understanding that organising effectively is not easy, takes time and that it is especially difficult to find out the common vision, but there was an overwhelming commitment to continue organising and develop a UK network of drug users groups. Suggestions of how to do this continued well into the night when the last samosa and orange juice had been consumed !

Since the meeting a number of drug user activists have been discussing how we move forward and a number of regional meetings, which are planned for January, with the aim of drawing together existing groups and promoting new groups,. A further national conference is being planed for later in the year, probably in Manchester.

There is a real chance to create a body to give a voice for drug users at a key time for UK drugs policy. The group has already been asked to brief a group of MPs on the arguments for repealing Paraphernalia Laws and hopefully this is only the beginning.

Chris Ford (SMP) & Beryl Poole, Brent Substance Users Rights Forum(BSURF)

References:

1. Dale A, Jones S, Power R. The Methadone Experience: the consumer view. Riverside Evaluation Project (Report), The Centre for research on Drugs and Health Behaviour. 1992.
2. Stimson G. has the United Kingdom averted an epidemic of HIV-1 infection amongst drug injectors ? Editorial Addiction (1996) 91(8), 1085-1088.

Positive About Drugs: The Essential Guide for HIV+ Gay Men Who Use Drugs is a new handbook published by Camden & Islington Health Promotion Service, for HIV+ gay men who use drugs. it contains the latest information on illicit drugs, their effects on the immune system and, following a much-published death attributed to a bad interaction between ritonavir (protease inhibitor) and ecstasy, an entire section on the possible interactions between HIV drugs and illicit ones. The focus is on the practical, explaining in clear and simple terms how drug users can help themselves to reduce the harm associated with their drug use. As a comprehensive and well-researched guide, it would also make the ideal desk-top reference handbook for use within GP practices. Copies are free to practices within Camden & Islington and are priced on a sliding scale for those outside. For more details or copies ring HIV team administrator on 0171.530.3900.

STOP PRESS

Any ideas for that conference speaker? Any views on drug users rights? Do you find motivational interviewing a useful tool and would you like to tell us about it? Would anybody like to write an article for the next newsletter? Has anyone worked out what to do about hepatitis C? Has anyone got an example of good shared care?
PLEASE let us know - THANK-YOU

Newsletter edited by Chris Ford, Brian Whitehead and Jean-Claude Barjolin. If you have contributions or suggestions please let us know. Or if you would like to join the mailing list for this newsletter, please contact: SMMGP Newsletter, Brent & Harrow Health Authority, Grace House, Harrovian Business Village, Bessborough Road, Harrow HA1 3EX P:0181.966.1109 Fax:0181.423.7314